

U.S. Department of Labor

Office of Administrative Law Judges
36 E. 7th St., Suite 2525
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)



Issue Date: 19 January 2007

Case No. 2005-BLA-5144

In the Matter of:
E.M.¹ OBO Estate of B.M.
Claimant,

v.

CUMBERLAND MOUNTAIN SERVICE
c/o AEI RESOURCES, INC.
Employer,

And
RAG AMERICAN COAL COMPANY
c/o ACORDIA EMPLOYERS SERVICE
Carrier,
And

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:
Ron Carson, Esq.
On behalf of Claimant

Carl Brasher, Esq.
On Behalf of Employer/Carrier

BEFORE: Thomas F. Phalen, Jr.
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

¹ The Department of Labor has directed the Office of Administrative Law Judges, the Benefits Review Board, and the Employee Compensation Appeals Board to cease use of the name of the claimant and claimant family members in any document appearing on a Department of Labor web site starting prospectively on August 1, 2006, and to insert initials of such claimant/parties in the place of those proper names. This order only applies to cases arising under the Black Lung Benefits Act, the Longshore and Harbor Workers' Compensation Act, and FECA. In support of this policy change, DOL has directed submission of a proposed rule change to 20 C.F.R. Section 725.477, proposing the omission of the requirement that decisions and orders of Administrative Law Judges contain the claimant/parties' initials only, to avoid unwanted publicity of those claimants on the web, and has installed software that prevents entry of the full names of claimant parties on final decisions and related orders. I strongly object to that policy change for reasons stated by several United States Courts of Appeal prohibiting such anonymous designations in discrimination legal actions, such as *Doe v. Frank*, 951 F. 2d 320 (11th Cir. 1992) and

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, (“the Act”) and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.²

On October 25, 2004 this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers’ Compensation Programs, for a hearing. (DX 39).³ A formal hearing on this matter was scheduled for April 18, 2006 in Harlan, Kentucky, by the undersigned Administrative Law Judge. (Tr. 1). However, all parties requested a decision be made on the record. (Tr. 4-6). All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES

The issues in this case are:

1. Whether Miner has pneumoconiosis as defined by the Act
2. Whether Miner’s pneumoconiosis arose out of coal mine employment;
3. Whether Miner is totally disabled;
4. Whether Miner’s disability is due to pneumoconiosis;
5. Whether Miner has one dependent for purpose of augmentation;
6. Whether the Miner has established a material change in conditions per §725.309(c),(d); and

those collected at 27 Fed. Proc., L. Ed. Section 62:102 (Thomson/West July 2005). Furthermore, I strongly object to the specific direction by the DOL that Administrative Law Judges have a “mind-set” to use the complainant/ parties’ initials if the document will appear on the DOL’s website, for the reason, *inter alia*, that this is not a mere procedural change, but is a “substantive” procedural change, reflecting decades of judicial policy development regarding the designation of those determined to be proper parties in legal proceedings. Such determinations are nowhere better acknowledged than in the judge’s decision and order stating the names of those parties, whether the final order appears on any web site or not. Most importantly, I find that directing Administrative Law Judges to develop such an initial “mind-set” constitutes an unwarranted interference in the judicial discretion proclaimed in 20 C.F. R. Section 725.455(b), not merely that presently contained in 20 C.F.R. Section 725.477 to state such party names.

² The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

³ In this Decision, “DX” refers to the Director’s Exhibits, “EX” refers to the Employer’s Exhibits, “CX” refers to the Claimant’s Exhibits, and “Tr.” refers to the official transcript of this proceeding.

7. Other issues which are indicated in Employer's letter dated April 8, 2002. (Item 18(a) & (b), DX 39).

(DX 39).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

B.M. ("Miner") was born on February 6, 1930. (DX 4). He never received any formal education. (DX 4). In August of 1955, Miner married E.M. ("Claimant"), and they remained married at the time this claim was filed. (DX 4). Miner has been married to no one else, has no dependent children, and lived with his wife at the time this claim was filed. (DX 4).

On his application for benefits, Miner alleged he engaged in underground coal mine employment for eleven years. (DX 4). Miner last worked in and around the coal mines in 1986, when he was advised to quit due to health problems. (DX 4). During his coal mine employment, Miner worked as a drill operator, standing for eight to ten hours a day while lifting and carrying over twenty pounds per day. (DX 6). Miner noted that he was awarded benefits for his Kentucky State Black Lung claim. (DX 4).

Procedural History

Miner filed his initial claim for benefits under the Act on June 9, 1986. (DX 1). That claim was denied by the District Director, Officer of Workers' Compensation on October 6, 1986. (DX 1). Following the submission of additional evidence, the claim was again denied on January 6, 1987, July 21, 1988, and March 31, 1989. (DX 1). After the final denial, Miner requested a formal hearing, and the matter was denied by an Administrative Law Judge on April 2, 1991. (DX 1).

On February 21, 1995, Miner filed a subsequent request for benefits under the Act. (DX 2). The Director issued a proposed decision and order – denial of benefits on August 1, 1995. (DX 2).

On August 12, 1996, Miner filed a third request for benefits under the Act, and that claim was denied by the District Director on July 11, 1997. (DX 3). The claim was again denied on a subsequent appeal to an Administrative Law Judge on May 27, 1999. (DX 3).

Miner filed the instant claim for benefits under the Act on April 12, 2001. (DX 4). On April 7, 2003, the District Director issued a Proposed Decision and Order denying benefits. (DX 28). The Director found that Miner established the presence of pneumoconiosis, that the disease was caused, at least in part, by Miner's coal mine work, but found that the miner was not totally

disabled by the disease. (DX 28). On May 8, 2003, Miner filed a timely request for a formal hearing before an Administrative Law Judge. (DX 31). On July 16, 2003, this matter was transferred to the Office of the Administrative Law Judges for a formal hearing. (DX 37). A formal hearing was scheduled to be held on June 22, 2004 in Benham, Kentucky. (DX 38). However, this office learned that Miner passed away and issued an order of remand to determine the proper party in this case. (DX 38). Claimant was subsequently appointed to appear on behalf of the estate of the Miner. (DX 38). At the parties' request, this decision was to be made based upon the record. (Tr. 4-6).

Length of Coal Mine Employment

Miner stated on his application that he engaged in coal mine employment for eleven years. (DX 4). The Director determined that Miner has at least eleven years of coal mine employment. (DX 28). This length of coal mine employment is clearly supported by the record. (DX 4, 5, 7). I therefore find that Miner has at least eleven years of coal mine employment.

Miner's last coal mine employment was in the Commonwealth of Kentucky (DX 1, 7, 21). Therefore, the law of the Sixth Circuit is controlling.⁴

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of Sections 725.494 and 725.495. The District Director identified Cumberland Mountain Service Corp. ("Cumberland" or "Employer") as the putative responsible operator. (DX 28). Given the clear employment evidence in the record,⁵ and absence of contrary evidence, I find that Cumberland is the responsible operator in this case.

Dependency

On August 15, 1955, B.M. married E.M., and she remained living with him until his death. (DX 1, 2, 3, 4). Miner has no dependent children. (DX 4). No evidence has been submitted to contradict the fact Miner was not married to Claimant, or that Claimant did not live with Miner at the time of his death. Therefore, I find Miner has one dependant for purposes of augmentation under Section 725.205.

NEWLY SUBMITTED MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas

⁴ Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc).

⁵ The record shows that Cumberland is Miner's only coal mine employer.

studies, no more than one report of each biopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be admissible under Section 725.414(a)(2)(i) and (3)(i) or Section 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of Sections 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under Section 725.414. § 725.406(b).

Miner selected Dr. Glen Baker to provide his Department of Labor sponsored complete pulmonary evaluation. (DX 8). Dr. Baker conducted the examination on September 6, 2001. (DX 9). I admit Dr. Baker's report under Section 725.406(b).

Claimant completed a Black Lung Benefits Act Evidence Summary Form, which I now admit into evidence. (CX 1). Claimant designated Dr. Baker's September 2001 x-ray, PFT, ABG, and medical report. (CX 1). Claimant also designed Miner's hospitalization records from East Tennessee Baptist Hospital and East Tennessee Heart Consultants. (DX 25). Claimant's evidence complies with the requisite quality standards of Sections 718.102-107 and the limitations of Section 725.414(a)(3). Therefore, I admit Claimant's designated evidence in its Summary Form.⁶

Employer completed a Black Lung Benefits Act Evidence Summary Form, which I now admit into evidence. (EX 4). Employer designated Dr. Lieber's x-ray of September 25, 2001⁷ and Dr. Burki's PFT of September 25, 2001⁸ as initial evidence. As neither exists in the record, they shall not be considered. Employer also designated Dr. Sargent, Dr. Kendall, and Dr. Poulos's reading of the Department's September 6, 2001 x-ray as rebuttal evidence.⁹ The regulations at § 725.414(a)(3)(ii) only permit the submission of one physician's interpretation of each chest x-ray as rebuttal evidence. This includes rebuttal of evidence offered pursuant to § 725.406. Thus, I shall only consider the x-ray interpretation of Dr. Kendall and exclude the interpretation of Dr. Poulos.¹⁰ I shall now admit Dr. Kendall's report regarding this x-ray as EX 3.

⁶ I have found some of the treatment record to be admissible. *See Supra* p. 8-10.

⁷ It was determined at the hearing that such an x-ray was not on the record, nor in the possession of either party. (Tr. 7). The parties agreed that it would not be used for consideration in this case. (Tr. 8). Therefore, even though it is indicated on Employer's Summary Form, it will not be considered in this case.

⁸ There is no PFT conducted by a Dr. Burki in the record. Employer points to "CX 2," but no such exhibit exists.

⁹ Dr. Sargent's reading of the x-ray was for quality purposes only.

¹⁰ I note that a show cause order here to require the Employer to choose an interpretation would not be in the interest of justice or promote judicial economy as both Drs. Kendall and Poulos are equally qualified and state the same thing.

Employer designated three medical reports as initial evidence: Dr. Hippensteel's report of July 19, 2002; Dr. Castle's report of July 18, 2002; and Dr. Castle's report of September 30, 2005. Given the limitations of Section 725.414(a)(3)(i), only two medical reports may be admitted. Dr. Castle's second report reflects upon the opinions of his first and gives further consideration to newly admitted evidence. As both of Dr. Castle's medical opinions come to the same conclusion, I will consider the latter under Section 725.414(a)(3)(i).¹¹ Thus, I now admit Dr. Castle's September 30, 2005 report as EX 2.

Employer also designed Miner's hospitalization records from East Tennessee Baptist Hospital and East Tennessee Heart Consultants.¹² (DX 25). As Employer's evidence complies with the requisite quality standards of Sections 718.102-107 and the limitations of Section 725.414(a)(3), with the exceptions of Dr. Poulos's x-ray, Dr. Castle's July 19, 2005 medical report, and the fact evidence from Drs. Lieber and Burki is non-existent, all other evidence is admitted for consideration in this claim.¹³

X-RAYS

Exhibit	Date of X-Ray	Date of Reading	Physician/Qualification	Film Quality	Interpretation
DX 12	9/06/2001	09/06/2001	Dr. Baker ¹⁴	2	1/0pp
DX 13	9/06/2001	10/11/2001	Dr. Sargent / B-Reader ¹⁵	1	Quality Only
EX 3	9/06/2001	05/28/2003	Dr. Kendall / B-Reader; BCR ¹⁶	2	Negative

¹¹ Both of Dr. Castle's opinions state the same thing; the latter merely restates the first, and inclusion of any two of the three the medical reports would not affect the outcome of this case. Thus, there is no reason for the Employer to seek admittance of both of Dr. Castle's reports. As such, I do not consider a show cause order here to be in the interests of justice or judicial economy.

¹² See *Infra* n. 6.

¹³ Given the number of deficiencies with Employer's submission of evidence, I strongly urge counsel to reexamine the evidentiary limitations of § 725.414.

¹⁴ At the time of the x-ray reading, Dr. Baker did not hold B-reader x-ray interpretation credentials. However, the August 29, 2005 "B-reader" list states that he was a B-reader from February 1, 1993 to January 31, 2001, and again from June 1, 2002 to present. He is also listed as an A-reader from February 1, 2001 to May 31, 2002.

¹⁵ A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.51) Consequently, greater weight is given to a diagnosis by a "B" Reader. See *Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

¹⁶ A "BCR" is a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. See 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

PULMONARY FUNCTION TESTS¹⁷

Exhibit/ Date	Co-op./ Undst./ Tracings	Age/ Height	FEV₁	FVC	MVV	FEV₁/ FVC	Qualifying Results	Comments
DX 11 9/06/2001	Fair/Good	71/66.7	1.74	2.38	71	73	No	

ARTERIAL BLOOD GAS STUDIES

Exhibit	Date	pCO₂	pO₂	Qualifying	Comments
DX 10	9/06/2001	40	81	No	

Narrative Reports

Dr. Glenn Baker examined Claimant on September 6, 2001 and submitted a report. (DX 9). Dr. Baker considered the following: an age of seventy-one years; an EKG report showing a normal sinus rhythm; eleven years of underground coal employment; a family history of cancer and stroke; personal history of wheezing, chronic bronchitis, arthritis, and heart disease; a smoking history of unknown duration – with Miner quitting his 1/3 pack a day in 1994; present symptoms of fifteen years of sputum production, daily wheezing, dyspnea, cough, chest pain, orthopnea, and ankle edema. Dr. Baker diagnosed coal worker's pneumoconiosis based upon an abnormal chest x-ray and Miner's history to coal dust exposure, COPD with a mild obstructive defect, chronic bronchitis, and ischemic heart disease. Dr. Baker stated that the miner's pulmonary impairment was mild, and that Miner had the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment.

Dr. Hippensteel¹⁸ reviewed a number of medical records and wrote a medical report stating his conclusions on July 19, 2002. (DX 27). He considered the September 2001 report by Dr. Baker, hospital records from October 15 – October 21, 2001, November 19 – December 2, 2001, February 2, 2002, February 22, 2002, and March 19, 2002, interpretation of a chest x-ray taken September 25, 2001 by Dr. Webber, a PFT report dated September 25, 2001, consultation notes by Dr. Hoadley dated February 8, 2002, an ABG dated February 8, 2002, and office notes by Dr. Doiron and his physician's assistant in January and February of 2002. After reviewing all the above evidence, Dr. Hippensteel states that it is impossible to conclude with a medical certainty if Miner has simple coal workers' pneumoconiosis, but he can conclude for certain that even if Miner had pneumoconiosis, it has in no way impaired his respiratory capacity and that his pulmonary condition would not hinder a return to his previous job in the mines. However, he notes that Miner's abdominal aortic aneurysm, deep vein thrombosis, and more drastically,

¹⁷ I note that Employer listed a PFT supposedly conducted by a Dr. Burki on September 25, 2001 on their Summary Form, which is designed by the Employer as "CX 2." I have searched the record extensively for a report by a "Dr. Burki," and have determined no such record exists in this case. Further, there is no exhibit marked as "CX 2," and Claimant's attorney explicitly stated they were relying only on Dr. Baker's reports. (*see* Tr. at 8).

¹⁸ Dr. Hippensteel's vita indicates he is board certified in internal and pulmonary medicine, and he holds a B-reader certification.

metastatic stomach cancer would prevent him from working in any capacity – but these conditions are unrelated to his prior coal mine employment.

Dr. James R. Castle¹⁹ submitted a medical report after examining the following medical documents: autopsy report by Dr. Blake dated September 24, 2002; Medical records from Baptist Hospital East Tennessee dated November 19 – December 2, 2001, which includes consultation reports by Drs. Powers and Doiron and a pathology report; x-ray dated November 19, 2001 and an accompanying report, a radiographic report on a film dated January 10, 2002, various notes from Dr. Doiron; hospital records with a discharge date of February 12, 2002; history and physical examination dated March 19, 2002; radiographic report by Dr. William Kendall on an x-ray film dated September 6, 2001; report on the same film by Dr. Alex Poulos; an independent medical review by Dr. Kirk Hippensteel dated July 19, 2002; and an independent medical review by himself dated July 18, 2002. (EX 2). After reviewing the above, Dr. Castle concludes with a reasonable degree of medical certainty that Miner did not suffer from coal worker's pneumoconiosis. He also states that while Miner was totally disabled, this was not as a result of any respiratory condition, but rather he was disabled as a consequence of severe cardiac disease and metastatic gastric carcinoma.²⁰ Dr. Castle concludes by stating that Miner's death was "not caused by, contributed to, or hastened in any way by coal workers' pneumoconiosis or a coal mine dust induced lung disease." Rather, he opines that Miner's death is the result of severe cardiac disease and the "sequelae thereof," and would have died at the same moment, regardless of his coal mine employment history.

Treatment Records

Both Employer and Claimant submitted medical records from East Tennessee Baptist Hospital ("Baptist Hospital") and East Tennessee Heart Consultants ("Heart Consultants") pursuant to 20 CFR Section 725.414(a)(4).²¹ Section 725.414(a)(4) allows for the admission of "any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease." § 725.414(a)(4). Therefore, if the hospital admission or treatment was based on a pulmonary impairment, the record is admissible notwithstanding the limitations in Sections 725.414(a)(2) and (a)(3). The records are summarized as follows:

¹⁹ Dr. Castle is certified in by the American Board of Internal Medicine and the American Board of Pulmonary Disease. Dr. Castle also holds a B-Reader certification.

²⁰ Dr. Castle specifically states "it is my opinion with a reasonable degree of medical certainty that [Miner] was not permanently and totally disabled during life as a result of any pulmonary process including coalworkers' pneumoconiosis." (EX 2).

²¹ Included in the treatment notes are x-ray reports from several physicians. There is no evidence in the record as to the x-ray reading credentials of these physicians. § 718.102(c). Also, these interpretations were all related to the treatment of Miner's condition, and not for the purpose of determining the existence or extent of pneumoconiosis. In addition, there is no record of the film quality for any of these x-rays. § 718.102(b). Finally, the interpreting physicians did not provide an ILO classification for their readings. § 718.102(b). As a result, these x-ray interpretations are not in compliance with the quality standards of § 718.102 and Appendix A to Part 718. Therefore, while I shall admit the reports under Section 725.414(a)(4), I accord the x-ray interpretations contained in the treatment records no weight for the purpose of determining whether Miner suffers from pneumoconiosis under § 718.202(a)(1).

October 15, 2001: Records from an admission to Baptist Hospital with a complaint of nausea. These hospital records follow a surgery which allegedly took place on October 1, 2001 where Miner underwent a resection of an eight centimeter abdominal aortic aneurysm. Records catalog treatment for this condition, as well as the nausea. While there is a passing mention of coal workers pneumoconiosis, there is no diagnosis made, nor is any treatment given. As such, this medical record is not admissible under § 725.414(a)(4).

November 19, 2001: Records from an admission to Baptist Hospital. Here, Miner underwent a distal two thirds gastrectomy and antecolic B II lysis of adhesions and needle catheter jejunostomy with known liver mets – this was done for cancer. In a physical to determine the possible success of an operation for a palliative removal of the gastric carcinoma, Dr. Graham notes that Miner’s lungs were “clear to auscultation anteriorly,” and believes that Miner suffered from COPD. Following the surgery, Miner is put under “postop respiratory management” to help deal with his “lung disease,” which is described as moderate COPD by Dr. Powers. The physical examination shows clear lung fields, a displaced PMI, and comfortable respiratory efforts. The notes also refer to a “not very severe chronic obstructive pulmonary disease by spirometry.” An ABG dated November 24, 2001 gives a PCO₂ of 32.8L and a PO₂ of 74L.²² Dr. Powers concludes by stating he will reinstitute bronchodilator therapy with albuterol and Atrovent. Here, while the original admission was not for the purpose of treating Miner’s lung disease, there is obvious medical treatment provided for a pulmonary condition while he was hospitalized. As such, I find these records to be admissible under § 725.414(a)(4).

January 10, 2002: Chest x-ray report from Baptist Hospital. This report does not include the quality of the x-ray, nor was it read for the purpose of determining the existence or extent of pneumoconiosis. Also, it does not contain the credentials of the interpreting physician. As a result, the x-ray results are not in compliance with the quality standards of § 718.102 and Appendix A to Part 718. Therefore, I accord this x-ray interpretation no weight for the purpose of determining whether Claimant suffers from pneumoconiosis.

January 11, 2002: Office note from Dr. Clint Dorion, Heart Consultants. Dr. Dorion notes that Miner has symptoms of coughing with the production of yellow sputum. Ultimately, Dr. Dorion diagnoses both bronchitis and COPD. As this treatment relates to a pulmonary condition, I find this record to be admissible under § 725.414(a)(4).

February 6, 2002: Office note from Dr. Clint Dorion, Heart Consultants. This report notes Miner visited the physician complaining that he was “not feeling well.” The illness related to palpitations – which resulted in weakness and a rapid heart beat. The only mention of the lungs is an “occasional rhonchi.” As such, I find these records do not relate to the treatment or diagnosis of a pulmonary impairment. Thus, this medical record is not admissible under § 725.414(a)(4).

February 8, 2002: Miscellaneous medical records from Baptist Hospital. Miner complained of shortness of breath on this visit. The record includes an ABG dated February 8, 2002 listing a

²² I note that while no sea level is provided with this ABG, the results would be non-qualifying under the tables found at Appendix C to Part 718, no matter what the sea level.

PCO₂ of 34.9L and a PO₂ of 84.²³ While Dr. David Schumaker finds the etiology of the impairment to be unclear, these treatment records are for the purpose of treating a pulmonary condition. As such, with the exception of the x-ray reports by Drs. John Stallworth and John Royer for reasons articulated below,²⁴ I find these records to be admissible under § 725.414(a)(4).

March 19, 2002: Miscellaneous medical records from Baptist Hospital. Miner is treated for extensive deep venous thrombosis in his left lower extremity. Dr. Clint Doiron makes no mention of any present impression of a pulmonary condition.²⁵ While there is an x-ray taken and interpreted by Dr. Scott Rosenbloom, it was not for the treatment of a pulmonary condition. As such, I find these records do not relate to the treatment or diagnosis of a pulmonary impairment. Thus, these medical records are not admissible under § 725.414(a)(4).

April 24, 2006: Letter from Dr. Clint Doiron, East Tennessee Heart Consultants. This is nothing more than a letter providing Dr. Doiron's opinion as to Miner's pulmonary condition and its contribution to his death. As this is not a medical record used in the treatment or diagnosis of a pulmonary impairment, it cannot be admitted under § 725.414(a)(4). However, as this can be admitted as a medical report, I shall admit the letter for consideration under 725.414(a)(3) and shall designate the letter as CX 2.

Included in the treatment notes are x-ray reports from several physicians.²⁶ There is no evidence in the record as to the x-ray reading credentials of these physicians. § 718.102(c). Also, these interpretations are all related to the treatment of Claimant's condition, and not for the purpose of determining the existence or extent of pneumoconiosis. In addition, there is no record of the film quality for any of these x-rays. § 718.102(b). Finally, the interpreting physicians did not provide an ILO classification for their readings. § 718.102(b). As a result, I find these x-ray interpretations are not in compliance with the quality standards of § 718.102 and Appendix A to Part 718. Therefore, I accord the x-ray interpretations contained in the treatment records no weight for the purpose of determining whether Claimant suffers from pneumoconiosis under § 718.202(a)(1).

Smoking History

Dr. Baker noted Miner stopped smoking a third of a pack a day in 1994, but does not list a starting date for smoking. (DX 9). Dr. Dorion states in the November 19, 2001 treatment records that Miner's history is negative for smoking, with smoking in the remote past. (DX 25). Due to the lack of evidence presented in this case, I cannot make a determination as to Miner's smoking history.

²³ I note again that while no sea level is provided with this ABG, the results would be non-qualifying under the tables found at Appendix C to Part 718, no matter what the sea level.

²⁴ *Supra* p. 11.

²⁵ He notes patient has a "history of COPD"

²⁶ The treatment record includes x-ray reports on the following dates: October 14, 2001; November 19, 2001 (two reports by Dr. Royer); November 27, 2001; January 10, 2002; February 8, 2002 (two reports by Drs. Royer and Stallworth; February 10, 2002; and March 19, 2002. I note even though they shall receive no consideration, none of the x-rays in the treatment records mention clinical pneumoconiosis.

DISCUSSION AND APPLICABLE LAW

Claimant's claim was made after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, that Miner:

1. Is a miner as defined in this section;
2. Has met the requirements for entitlement to benefits by establishing that Miner:
 - (i) Has pneumoconiosis (see § 718.202);
 - (ii) The pneumoconiosis arose out of coal mine employment (see § 718.203);
 - (iii) Is totally disabled (see § 718.204(c));
 - (iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and
3. Has filed a claim for benefits in accordance with the provisions of this part.

Section 725.202(d)(1-3); *see also* §§ 718.202, 718.203, and 718.204(c).

Subsequent Claim

The provisions of Section 725.309 apply to new claims that are filed more than one year after a prior denial. Section 725.309 is intended to provide claimants relief from the ordinary principles of *res judicata*, based on the premise that pneumoconiosis is a progressive and irreversible disease. *See Lukman v. Director, OWCP*, 896 F.2d 1248 (10th Cir. 1990); *Orange v. Island Creek Coal Company*, 786 F.2d 724, 727 (6th Cir. 1986); § 718.201(c) (Dec. 20, 2000). The amended version of Section 725.309 dispensed with the material change in conditions language and implemented a new threshold standard for the claimant to meet before the record may be reviewed *de novo*. Section 725.309(d) provides that:

If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part, the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subparts E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see § 725.202(d) miner. . .) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:

(1) Any evidence submitted in conjunction with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.

(2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of the subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.

(3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence establishes at least one applicable condition of entitlement. . . .

(4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue, shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

§ 725.309(d) (April 1, 2002).

Miner's prior claim was denied after it was determined that he failed to establish any of the elements of entitlement. (DX 1). Consequently, the Claimant must establish, by a preponderance of the newly submitted evidence, at least one applicable condition of entitlement previously adjudicated against Miner.

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under Section 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.

(1) *Clinical Pneumoconiosis*. “Clinical pneumoconiosis” consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers’ pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) *Legal Pneumoconiosis*. “Legal pneumoconiosis” includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For the purposes of this section, a disease “arising out of coal mine employment” includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, “pneumoconiosis” is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

§§ 718.201(a-c).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. The record contains only one x-ray. Dr. Baker, who possesses A-reader credentials, and was thus neither a B-reader nor BCR certified at that time, interpreted the September 9, 2001 film as positive for 1/0 pp pneumoconiosis. Dr. Kendall, who possesses B-Reader and BCR credentials, interpreted the same film to be negative for pneumoconiosis. Given the superior credentials of Dr. Kendall, I find the September 9, 2001 film to be negative for pneumoconiosis.

As the only x-ray is negative for pneumoconiosis,²⁷ I find that the preponderance of the chest x-ray evidence establishes that there is no pneumoconiosis. Therefore, I find that Claimant has failed to establish the presence of pneumoconiosis under subsection (a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. The evidentiary record does not contain any biopsy evidence. Therefore, I find that the Claimant has failed to establish the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

²⁷ I have already determined that the x-ray reports submitted with the treatment records are not in compliance with the quality standards of §718.102 and Appendix A to Part 718. Thus, they shall not receive consideration.

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director*, OWCP, 7 B.L.R. 1-860 (1985).

Dr. Baker opined Miner has pneumoconiosis based solely upon his own readings of a chest x-ray and Miner's history of dust exposure. (DX 9). In *Cornett v. Benham Coal Inc.*, 227 F.3d 569 (6th Cir. 2000), the Sixth Circuit Court of Appeals intimated that such bases alone do not constitute sound medical judgment under Section 718.202(a)(4). *Id.* at 576. The Board has also held permissible the discrediting of physician opinions amounting to no more than x-ray reading restatements. See *Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993)(citing *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113 (1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-405 (1985)). In *Taylor*, the Board explained that the fact that a miner worked for a certain period of time in the coal mines alone does not tend to establish that he has any respiratory disease arising out of coal mine employment. *Taylor*, 8 B.L.R. at 1-407. The Board went on to state that, when a doctor relies solely on a chest x-ray and a coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his or her opinion "merely a reading of an x-ray... and not a reasoned medical opinion." *Id.*

Dr. Baker provided Claimant's Department of Labor sponsored pulmonary examination on September 6, 2001. Acknowledging that Dr. Baker performed other physical and objective testing, he listed that he expressly relied on Miner's positive x-ray and coal dust exposure for his clinical determination of coal workers' pneumoconiosis. Moreover, he failed to state how the results from his other objective testing might have impacted his diagnosis of coal workers' pneumoconiosis. As he did not indicate any other reasons for his diagnosis of coal workers' pneumoconiosis beyond the x-ray and exposure history, I find his report with respect to a diagnosis of clinical pneumoconiosis unreasoned and give it little weight.

In addition, Dr. Baker diagnosed Miner with chronic bronchitis and COPD based on his history of cough, sputum production, wheezing, and the PFT results. Dr. Baker asserted that these conditions were the result of Miner's coal dust exposure and a cigarette smoking. However, Dr. Baker's notes included an extremely vague smoking history. Even though Dr. Baker relied upon objective data and personal observations in regards to the diagnosis of legal pneumoconiosis, he was vague with how much of a smoking history he relied upon. Thus, I find his report to be unreasoned regarding legal pneumoconiosis and give it little weight.²⁸

In a letter dated April 19, 2006, Dr. Clint Doiron states he treated miner for nearly eighteen years and knew his medical problems very well. He asserts that Miner suffered from a significant case of coal workers' pneumoconiosis that would contribute to a cardiopulmonary strain and exertional hypoxemia thereby contributing to and aggravating myocardial ischemia associated with Miner's coronary artery disease. However, Dr. Dorion relies upon x-rays that have not been admitted into evidence.²⁹ Further, he states that CWP was confirmed by "postmortem findings," but there is no evidence in the record to support such an assertion. As Dr. Dorion does not rely upon admitted evidence and fails to document objective testing to support his assertion, I find Dr. Dorion's diagnosis of CWP to be both undocumented and unreasoned. Therefore, I accord his opinion with little weight.

Dr. Dorion also states that Miner suffered from COPD as evidenced by his frequent bouts of wheezing and coughing, especially with exertion. In his letter however, Dr. Dorion fails to articulate how COPD relates to Miner's coal mine employment as required under §

²⁸ The District Director is required to provide each miner applying for benefits with the "opportunity to undergo a complete pulmonary evaluation at no expense to the miner." § 725.406(a). A complete evaluation includes a report of the physical examination, a chest x-ray, a pulmonary function study, and an arterial blood gas study. Reviewing courts have added to this burden by requiring the pulmonary evaluation be sufficient to constitute an opportunity to substantiate a claim for benefits. See *Petry v. Director*, OWCP 14 B.L.R. 1-98, 1-100 (1990)(*en banc*); see also *Newman v. Director*, OWCP, 745 F.2d 1161 (8th Cir. 1984); *Prokes v. Mathews*, 559 F.2d 1057, 1063 (6th Cir. 1977).

²⁹ In this Decision and Order, I have found that Miner's complete pulmonary evaluation by Dr. Baker is unreasoned for purposes of determining pneumoconiosis and total disability. However, even if this claim were remanded to the Director to provide a reasoned and documented opinion concerning the existence of pneumoconiosis and total disability, Claimant could not prevail based on the preponderance of the evidence. Therefore, I find that remand of this case would be futile. *Larioni v. Director*, OWCP, 6 B.L.R. 1-1276 (1984); see, e.g., *Mullins v. Director*, OWCP, No. 05-0295 BLA (BRB, Jul. 27, 2005)(unpub.); *Bowling v. Director*, OWCP, No. 05-0327 BLA (BRB, Jul. 29, 2005)(unpub.).

²⁹ It is not clear what x-rays he relied upon.

718.201(a)(2).³⁰ Further, he fails to note any objective testing he may have considered in coming to his conclusion. As such, even though Dr. Dorion was Miner's treating physician, I find this medical report to be unreasoned and undocumented and give it little weight.

Dr. Hippensteel reviewed numerous medical records and opined that it is impossible to conclude with a medical certainty if Miner has simple coal workers' pneumoconiosis. (DX 27). An opinion may be given little weight if it is equivocal or vague. *Island Creek Coal Co. v. Holdman*, 202 F.3d 873 (6th Cir. 2000) (a physician, who concluded that simple pneumoconiosis 'probably' would not disrupt a miner's pulmonary function, was equivocal and insufficient to 'rule out' causal nexus as required by 20 C.F.R. §727.203(b)(3)); *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995) (treating physician's opinion entitled to little weight where he concluded that the miner 'probably' had black lung disease); *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988) (an equivocal opinion regarding etiology may be given less weight); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236 (1984) (equivocal regarding disability); *Amax Coal Co. v. Director, OWCP [Chubb]*, 312 F.3d 882 (7th Cir. 2002) (under Part 727, the ALJ properly discredited the opinion of Dr. Meyers as too equivocal because he found that the miner suffered from a 'significant limitation,' but 'it appeared more cardiac than pulmonary'). See also *White v. New White Coal Co.*, 23 B.L.R. 1-1 (2004). Because his statement is ambiguous and comes to no conclusion, I shall accord his opinion regarding coal worker's pneumoconiosis no weight. He makes no statements or conclusions regarding legal pneumoconiosis.

Dr. Castle, a Board-certified Internist, Pulmonologist, and B-Reader, submitted a medical report after examining numerous treatment records and opined with a reasonable degree of medical certainty that Miner did not suffer from coal workers' pneumoconiosis. (EX 2). He based this upon the Miner's medical histories, physical examinations, radiographic evaluations, physiologic testing, hospital records, and an autopsy report.³¹ As not one of the x-rays he examined was positive for pneumoconiosis,³² and since other objective data does not support such a finding, he determined that Miner did not suffer from coal workers' pneumoconiosis. As his opinion is based upon objective evidence I find it to be well reasoned and well documented. Thus, even though Dr. Castle never personally examined Miner, due to his advanced credentials, I accord his opinion some weight.

Dr. Castle states that Miner's COPD is most likely the result of either tobacco use or Miner's cardiac disease. Dr. Castle notes that Miner's smoking history is vague, but there is an indication he was a heavy smoker at one point in his life which would "likely" result in the development of chronic bronchitis/emphysema or atherosclerotic disease. Also, Dr. Castle notes that cardiac disease, which Miner has a documented history of, is also a likely cause of Miner's

³⁰ See *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000) where the court emphasized the distinction between legal and medical pneumoconiosis; a miner's exposure to coal mine employment must merely contribute "at least in part" to his pneumoconiosis; see also *Anderson v. Director, OWCP*, ___ F.3d ___, Case No. 05-9550 (10th Cir. July 25, 2006), where the court held that the ten year rebuttable presumption at 20 C.F.R. § 718.203 applies only to determine whether the miner's clinical pneumoconiosis is coal dust related. On the other hand, with regard to legal pneumoconiosis, the miner must demonstrate that his respiratory ailment, i.e. chronic obstructive pulmonary disease, was caused by coal dust exposure without use of the ten year presumption.

³¹ Even though the autopsy report and some of the x-rays are not admitted into evidence, it appears Dr. Castle did not rely heavily on these reports.

³² This includes the x-ray I have determined to be negative for coal workers' pneumoconiosis.

pulmonary impairments. As Dr. Castle points to specific medical evidence (most convincingly – Miner’s cardiac condition) as a cause for Miner’s pulmonary condition (COPD), I find his opinion to be well reasoned and well documented. As such, I accord his opinion probative weight.

The admitted treatment records of November 19, 2001, January 11, 2002, and February 8, 2002 make no diagnosis of coal workers’ pneumoconiosis. However, in each instance, the doctors involved diagnose some form of a pulmonary condition, be it bronchitis and/or COPD. In the November 19, 2001 record, one doctor even stated Miner suffers from a “lung disease.” Thus, even though coal worker’s pneumoconiosis is never diagnosed, there is ample evidence to suggest legal pneumoconiosis.

However, under the statute, any doctor diagnosing legal pneumoconiosis must clearly articulate that the pulmonary condition is the result of coal mine employment. § 718.201(a)(2); *See also Anderson v. Director, OWCP*, ___ F.3d ___, where the court held that with regard to legal pneumoconiosis, the miner must demonstrate that his respiratory ailment, i.e. chronic obstructive pulmonary disease, was caused by coal dust exposure without use of the ten year presumption. Here, none of the doctors’ notes that diagnose a pulmonary condition specifically state that the condition is the result of coal mine employment. Thus, with regards to diagnosing legal pneumoconiosis, I accord the treatment records no weight.

With regards to clinical pneumoconiosis, I accorded Dr. Baker’s opinion little weight, Dr. Dorion’s with little weight, Dr. Hippensteel’s with no weight, and Dr. Castle’s with some weight. Here, I am most convinced by Dr. Castle’s opinion as he pointed to objective data he relied upon. As such, I find Claimant has failed to establish by a preponderance of the evidence that Miner suffered from clinical pneumoconiosis.

Concerning the determination of legal pneumoconiosis, I have accorded Dr. Baker’s opinion little weight, Dr. Dorion’s with little weight, Dr. Castle’s with probative weight, and the treatment records with no weight.³³ I am persuaded by Dr. Castle’s opinion as he points to objective data and provides a logical rationale for Miner’s pulmonary condition. As such, I find Claimant has failed to establish by a preponderance of the evidence that Miner suffered from legal pneumoconiosis.

Claimant has failed to establish the presence of pneumoconiosis under subsection (a)(1)-(4). Therefore, after weighing all evidence of pneumoconiosis together under Section 718.202 (a), I find that Claimant has failed to establish the presence of pneumoconiosis.

The newly submitted evidentiary record does not establish the presence of pneumoconiosis. Claimant may still prevent her subsequent claim from being denied on the basis of the prior denial by establishing the existence of a totally disabling respiratory or pulmonary impairment.

³³ I note Dr. Hippensteel made no statements regarding legal pneumoconiosis.

Causation of Pneumoconiosis

Once pneumoconiosis has been established, the burden is upon the Claimant to demonstrate by a preponderance of the evidence that the pneumoconiosis arose out of the miner's coal mine employment. 20 C.F.R. § 718.203 (2003).

If a miner suffers from pneumoconiosis and was employed ten years or more in the Nation's coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b); *Stark v. Director*, OWCP, 9 B.L.R. 1-36 (1986); *Hucker v. Consolidation Coal Co.*, 9 B.L.R. 1-137 (1986). As I have found that Miner has established eleven years of coal mine employment, if I had found that he suffered from pneumoconiosis, he would be entitled to the rebuttable presumption set forth in § 718.203(b) that his pneumoconiosis arose out of his coal mine employment. However I have found that Claimant does not have pneumoconiosis. Because there is no pneumoconiosis, I find there is no causation.

Total Disability

Claimant may also establish a material change in conditions by demonstrating that Miner is totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis under one of the five standards of § 718.204(b) or the irrebuttable presumption referred to in § 718.204(b). The Board has held that under § 718.204(b), all relevant probative evidence, both like and unlike must be weighed together, regardless of the category or type, in the determination of whether the Claimant is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

There is no evidence of complicated pneumoconiosis in the record. Therefore, the irrebuttable presumption of § 718.304 does not apply.

Total disability can be shown under § 718.204(b)(2)(i) if the results of pulmonary function studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. Also, in *Crappe v. U.S. Steel Corp.*, 6 B.L.R. 1-476 (1983), the Board held that a non-conforming PFT may be entitled to probative value where the study was not accompanied by statements of miner cooperation and comprehension and the ventilatory capacity was above the table values. This is because any deficiency in cooperation and comprehension could only result in higher results.

The only PFT contained in the record was conducted on September 6, 2001 by Dr. Baker. The results of this study produced non-qualifying results. Therefore I find that Claimant has failed to establish the existence of total disability under subsection (b)(2)(i).

Total disability can be demonstrated under Section 718.204(b)(2)(ii) if the results of ABGs meet the requirements listed in the tables found at Appendix C to Part 718. The ABGs conducted on September 6, 2001, November 19, 2001, and February 8, 2002 did not produce

qualifying values that meet the requirements of the tables found at Appendix C to Part 718. Therefore, I find that Claimant has failed to establish the existence of total disability under subsection (b)(2)(ii).

Total disability may also be shown under Section 718.204(b)(2)(iii) if the medical evidence indicates that Miner suffers from cor pulmonale with right-sided congestive heart failure. The record does not contain any evidence indicating that Claimant suffers from cor pulmonale with right-sided congestive heart failure. Therefore, I find that Claimant has failed to establish the existence of total disability under subsection (b)(2)(iii).

Section 718.204(b)(2)(iv) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine employment or comparable gainful employment. Claimant's usual coal mine employment was working as a drill operator during the eleven years of his employment, requiring him to stand for eight to ten hours a day while lifting over twenty pounds. (DX 5, 6).

The exertional requirements of the claimant's usual coal mine employment must be compared with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a prima facie finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to section 718.204(b)(1). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. Section 718.204(a); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (1994). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element. *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986).

While Dr. Baker never strictly stated whether Miner was or was not totally disabled, he noted that Miner suffered from a "mild pulmonary impairment" as a result of coal mine employment. (DX 9). Dr. Baker further stated that Miner retained the respiratory capacity to perform the work of a coal miner or to perform the comparable work in a dust-free environment. Dr. Baker considered an accurate employment history: eleven years as a drill operator. Given that Dr. Baker physically examined the Miner and relied upon objective testing (PFT, ABG) in making his determination as to the level of Miner's pulmonary disability, I find his statement that Miner could perform the work of a coal miner or to perform the comparable work in a dust-free environment to be well documented and well reasoned. As such, I accord his opinion probative weight.

Dr. Hippensteel submitted a medical report on July 19, 2002. (DX 27). Even though he stated it was impossible to determine from the evidence whether Miner suffered from a simple case of pneumoconiosis, he asserted he could conclude for certain that Miner retained the respiratory capacity to return to the mines and was thus not totally disabled. I note he considered

an accurate employment history of eleven years as a drill operator. Dr. Hippensteel noted that other physical conditions of the Miner (i.e., abdominal aortic aneurysm, deep vein thrombosis, and metastatic stomach cancer would prevent him from working in any capacity), would render him from working in any capacity, but these conditions were not pulmonary in nature. Given that Dr. Hippensteel based his opinion in this matter upon objective evidence such as ABGs and numerous medical treatment notes, I find his opinion to be well documented and well reasoned regarding total disability. Thus, I accord his opinion probative weight.

Dr. Dorion makes no statements regarding total disability in his letter dated April 19, 2006. (CX 2). He only states that Miner “had significant coal workers’ pneumoconiosis that would contribute to a cardiopulmonary strain and exertional hypoxemia – thereby contributing to and aggravating myocardial ischemia associated with his coronary artery disease.” As he makes no statements regarding total disability or Miner’s capacity to return to work, or a similar position in a dust related environment, and points to no objective data that would show total disability, I find his opinion regarding total disability to be undocumented, unreasoned, and accord it no weight.

Dr. Castle examined Miner’s treatment records from both Baptist Hospital and Heart Consultants, records from Dr. Baker’s examination (including objective testing), and an autopsy report. After having examined all the medical records, objective tests, and Claimant’s employment history of eleven years as a drill operator, Dr. Castle concluded with a reasonable degree of medical certainty that Claimant was not permanently and totally disabled as the result of a pulmonary condition.³⁴ He did state that Miner was disabled due to a case of severe cardiac disease and metastatic gastric carcinoma, but this is not pulmonary in nature. As Dr. Castle relied upon objective data to draw his conclusions, I find his opinion to be well documented and well reasoned. Noting Dr. Castle’s credentials, I afford his conclusions concerning total disability probative weight.

Here, there are three medical opinions which state Miner was not totally disabled due to a pulmonary condition and could return to his former coal mine employment³⁵ and one that is silent on the issue (and I accorded it no weight). As such, I find that Claimant has not proven by a preponderance of the evidence that Miner could not return to his former coal mine employment or one of comparable and gainful employment as required under Section 718.204(b)(2)(iv).

Accordingly, taken as a whole, the medical narrative evidence does not support a finding of total pulmonary disability. There are no qualifying PFTs, ABGs, or even a medical opinion to support total disability. Taking the evidence as a whole, I find that Claimant has failed to establish total pulmonary disability or total disability due to pneumoconiosis under Section 718.204(b)(iv).

³⁴ I note Dr. Castle reviewed an autopsy report which is not in evidence. I find that his consideration of this evidence not in the record would not alter his opinion on the Miner’s total disability during his life, as Dr. Castle relies upon other objective data to draw his conclusion regarding total disability.

³⁵ The doctors found he could return to his work based upon Miner’s pulmonary capacity – not his total physical capacity.

Claimant has failed to establish that Miner is totally disabled under subsection (b)(2)(i)-(iv). Therefore, after reviewing all of the newly submitted medical evidence concerning total disability under Section 718.204 (b), I find that Claimant has failed to establish that he is totally disabled due to pneumoconiosis.

Entitlement

Claimant has failed to establish a material change in conditions sufficient to meet the statutory requirements of Section 725.309(d) because she has failed to prove Miner suffers from pneumoconiosis, or that he is totally disabled due pneumoconiosis. Therefore, Claimant is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the claim of E.M. OBO the estate of B.M. for benefits under the Act is hereby DENIED.

A

THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this decision, by filing notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013- 7601. *See* 20 C.F.R. §§ 725.478 and 725.479. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).